PSA

Patient Safety America Newsletter

September 2010 http://PatientSafetyAmerica.com John T. James, Ph.D.

Question: A recent study has shown that 1/3 of older patients admitted to hospitals are taking inappropriate medications. In this huge group of patients what fraction of admissions were directly attributed to the inappropriate medications? A) 10% b) 20% c) 30% d) 40% e) 50%

Can Self-Regulation of Physicians Continue?

There are many difficult aspects to being a physician. New medical information flows at an ever-increasing rate, new technologies appear overnight, workloads increase unabated, and patients are often non-compliant with treatment plans. There is one more challenge to being a physician that many of us overlook. Are physicians prepared and willing to report an impaired or incompetent colleague? Willingness to do this is at the core of a self-regulating professional community. A recent study published in the *JAMA* suggests that this aspect of self-regulation is not working very well for physicians.[1]

Very few of us enjoy "snitching" on a colleague because we know this could ruin a friendship, lead to unpleasant confrontations, and get us labeled as a tattle-tale. Furthermore, impairment and incompetence may become apparent gradually. At what point has a colleague crossed the threshold where he must be reported? Will the authorities to whom I report my colleague act fairly? The tension between physicians and hospital administrators is palpable in many hospitals. Could my reporting backfire? It is in this context that we expect physicians to report impaired or incompetent colleagues – an almost superhuman expectation.

A team of investigators set out to determine how effectively physicians report impaired or incompetent colleagues.[1] They began with a nationally-representative sample of about 2,000 physicians in a variety of specialties. Surprisingly, only 2/3 of the respondents agreed with the professional commitment to always report impaired or incompetent colleagues. Just under 1/5 of the doctors had direct personal knowledge of an incompetent colleague and 1/3 of those had not reported their incompetent colleague to relevant authorities. The authors view this result as a lower bound on the true number of unreported incompetent or impaired doctors. The main reasons for non-reporting were as follows: someone else will, nothing will happen, fear of retribution, not my job, and excessive punishment of colleague. The investigators questioned the ability of the physician community to self regulate. They end their report as follows: "Reliance on the current process results in patients being exposed to unacceptable levels of risk and impaired or incompetent physicians possibly not receiving the help they need."

One point I would add is that the physician community is not likely to create a rigorous system of self-regulation without pressure from outside their professional community. Pressure must come from those of us who will one day be a patient hoping that our life is in the hands of unimpaired and fully-competent physicians.

CLABSI the Patient Killer

OK, I'll admit that I did not know what the acronym "CLABSI" meant before I read the commentary I'm about to summarize. CLABSI refers to Central Line Associated Bloodstream

Infections. Central lines are inserted into large veins so that medications can be administered and blood pressure readings sometimes taken. One of the hospitals in my area has a poor record with CLABSI. Nation-wide the number of CLABSI-associated deaths each year (31,000) is nearly as high as deaths from automobile accidents (34,000). In the opinion of Peter Pronovost, MD, a well known proponent of improved patient safety, CLABSI can be prevented for the most part.[2] The Secretary of the DHHS has called for a reduction of 50% in CLASBI over the next three years, yet hospital participation remains lackluster.

There are checklists for proper insertion of central line catheters and use of these has nearly eliminated CLABSI in some hospitals. So what happens if a nurse sees a senior physician out of compliance with the checklist? Would she speak up and ask the physician to comply? The most common answer is "there is no way the nurse would speak up." Dr. Pronovost asks, "What other industry would accept a routine safety violation that is associated with the deaths of tens of thousands of patients and not be held accountable? The US health care culture still does not support the questioning of physician behavior." Behavioral deficiencies are often driven by arrogance and lack of willingness to recognize that patient treatment is a team effort.

The author makes a call for better accountability in the prevention of CLABSI. He directs that accountability at clinicians who insert these catheters and hospital administrators who can monitor and influence infection rates through discipline and culture changes. If you can find a copy of the July 14 *JAMA* at your local library, I would recommend reading this short article. It avoids medical jargon and declares a clear mandate that CLABSI must become history. An informed patient, just like a careful driver, is one who stands a better chance of surviving the experience.

Contextual Medical Errors

As if there are not enough types of medical error, a group of physicians and other experts have presented us with a new (to me) kind of medical error. They call this a contextual error.[3] By this they mean an error caused when a physician does not consider the patient's unique needs and limitations that bear on a successful outcome of treatment. The premise is that a physician should question a patient in sufficient depth to discover contextual factors that could affect treatment. This is parallel to the questions a physician ought to ask a patient to uncover key biomedical factors that could affect treatment. Contextual factors might include: ability of patient to comply with treatment, ability to afford medications, and access to follow-up care. The authors emphasize that such errors reflect failure to individualize a patient's care.

This study had an interesting design. Actors were trained to appear as patients before an internal medicine physician and pretend to present hints that the doctor needed to ask more questions to discover key contextual information. The actors were also trained to give clues that the physician needed to probe for biomedical clues to get correct treatment. The four general scenarios were uncomplicated visits, biomedically-complicated visits, contextually-complicated visits, and combined contextual and biomedical complexity. The actors' visits were mixed in with the physicians' normal patient flow and were not evident to the internist.

Looking at the combined errors (failure to probe after the hint) in the four categories, the investigators found that physicians provided error-free care as follows: uncomplicated (3/4), biomedically complicated (2/5), contextually complicated (1/5), and combined (1/10). The investigators point out some limitations to their study, but I must ask if this sort of probing by actors could address the problem of self-regulation noted in the first study I study summarized on page 1. Healthcare consumers could make much smarter choices if they knew an individual physician's error rate as demonstrated by actor probes. Physicians knowing that any patient may be a test-plant might also be more thorough in how they probe for contextual and biomedical factors necessary to consistently deliver error-free care.

Lifestyle Medicine

Most of us have something about our lifestyle that places us at higher risk for chronic illnesses. The list of lifestyle "medications" include the following: no tobacco use, alcohol in moderation, plenty of vigorous exercise, and weight control through limiting calorie intake. Some might look at this list and exclaim, "Then what is the point of living if I cannot eat, drink, and be merrily sedentary." I do not have a crisp answer for that. I am married to an excellent cook, so calorie management is always a problem for me. I enjoy outside exercise, but conditions in Houston these days are oppressive for vigorous exercise. I have excuses. None-the-less, I try to take large doses of lifestyle medicine. A recent commentary by two MDs in the *JAMA* asks how well prepared physicians are to "prescribe" lifestyle medicine.[4] They cite a number of studies suggesting that doctors and their patients need plenty of improvement in this area.

For example, almost 1/5 of patients with heart disease continue to smoke and only 1/10 of patients with diabetes follow dietary recommendations on limiting intake of saturated fat. Obese patients without any chronic illness are advised to lose weight by their doctors only 1/3 of the time, and only ¼ of smokers were offered help in smoking cessation by their doctors. One cited study found that a well-structured reinforcement program, starting with physician recommendations for walking exercise, resulted in a 5-fold increase in exercise by supported patients when compared to patients without support in exercising.

The authors propose a 5-part competency assessment tool to be given to primary-care doctors. The goal is to make doctors more aware of the need for lifestyle medicine and the strategies and tools available that can be offered to patients. We as patients must do our part by asking our doctors for their help when we know we need it, and then following through on their recommendations. As in most aspects of medicine, patients and doctors must improve communication.

Another Attack on Diagnostic Errors

Two MDs have proposed a 5-front "attack" on diagnostic errors in the context of the medical-home concept of primary care. They call their 5 strategies "5 rights" in a sense that the right strategies are employed.[5] The five strategies are teamwork, information management, monitoring, patient empowerment, and a culture of safety. I almost fell out of my chair when I saw "patient empowerment." Some of the doctors' suggestions may be of special interest to you as a patient.

Teamwork is critical in healthcare. Careless handoffs between physicians can lead to diagnostic errors. One of the major complaints I have heard from patients is the difficulty in getting their records from one doctor to another. In a well run medical home this would never happen. You may recall a study I summarized recently in which the average time for a newly discovered aortic aneurysm to be posted in VA patient's medical records was 237 days.[6] Such delays in diagnosis cannot happen with adequate teamwork.

Information management depends on availability of electronic medical records. These systems must be reliable and trusted by doctor and patient. Alerts in these records can help with accurate diagnosis, but a flood of alerts leads to inattention that can cause a missed diagnosis. Likewise, patients must be monitored to obtain the data that becomes actionable information. The ability of physicians to make accurate diagnoses could also be monitored.

Patient empowerment is refreshing to hear from physicians. To quote the authors: "Because [diagnostic] errors are common, clinicians must also enlist patients as key partners in error prevention and detection." Patients must learn to ask critical questions about their care. The authors call these "activating" questions. An example would be, "How will I receive the results from my blood work?" The right safety culture is critical to doing as much as humanly possible to get a right diagnosis. I work in

the space industry where a safety culture is critical to safe human spaceflight. Certain principles are paramount as they should be in healthcare: anyone can raise a safety concern without retribution, systems are established to gain thorough input into key decisions, and lessons are learned from mistakes or near misses.

If you are going to join a medical home for healthcare, then look for these five principles in action. Is there obvious teamwork and rigorous management of your records? Ask how quality of diagnosis and treatment is monitored. Be an empowered patient, and then expect your questions and input to be valued. Finally, ask how the medical home identifies errors and learns from them.

Dangerous Delirium Diagnosed

According to a perspective report by Bridget Kuehn in the *JAMA*, a large fraction of hospitalized patients experience delirium and this dangerous condition is often undiagnosed.[7] Delirious patients may be confused, cognitively impaired, or have hallucinations. Delirium is caused by progressive failure of critical organs, especially those associated with the nervous system. The 6-month death rate for patients that have had delirium in the hospital is more than twice that of patients that did not have this condition. Delirium can be effectively diagnosed by a trained nurse in less than a minute, yet physicians agree that delirium is widely under diagnosed.

Once delirium is diagnosed, treatment must be quick. The causes can be infection, malnutrition, therapeutic drugs, sleep deprivation, or withdrawal from chemical dependence or medication. Careful selection of drugs and early exercise can minimize delirium. If you are a patient advocate for a seriously ill, hospitalized family member you are likely to know their normal behavior. If the patient you are looking after is behaving in an unusual way, then ask a nurse or doctor for an evaluation to see if delirium is occurring. Do not accept strange behavior of your loved one as a normal course of events during hospitalization. Your informed action and questioning may save their life.

References

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Answer to question this month: e) 50% according to a study from 2008 cited in reference 8